Nutrition Health Intake

Name _____ SSN _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Phone _____

Email _____ Marital Status: Single Married Divorced Widow

Occupation _____ Employer _____

Do you primarily: sit stand perform repetitive tasks other_____

Spouse Name _____ Spouse Employer _____

How many children? _____ Names and ages of children _____

_____

How were you referred to our office? _____

Have you seen a chiropractor before? Y N If yes, who and when _____

Do you feel your previous chiropractic care was effective? Y N Please explain _____

_____

Have you had x-rays of your spine in the past 2 years? Y N Where taken? _____

Do you currently wear the following: mouthguard/bite splint C-PAP heel lift orthotics

Check any insurance coverage that may be applicable in this case:

Health Insurance Health Sharing Medicare Auto Accident/Personal Injury HRA/Flex

Terms of Acceptance: Health is defined as a state of complete physical, mental, and social well-being not merely the absence of disease or infirmity. Our goals are to provide a detailed holistic assessment of your current health status and provide you with resources to achieve health. Our initial consultation will outline a detailed holistic approach for nutrition and dietary advice to support natural body processes and healing. We focus on ways to help YOU by looking to the underlying or root cause of your current problem. This means we look deeper than symptoms and look for a breakdown of a specific organ, system, or body function. In many cases our daily lifestyle that is full of chronic excessive stress, poor diet, lack of nutrition, sleep deficiency, sedentary lifestyles, and poor detoxification can lead to this breakdown. We may recommend special laboratory testing to further evaluate or determine the root cause of your condition or to further customize your health program for your body's needs.

HIPAA Notice: I understand and agree to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like to have a more detailed description of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice posted in the waiting room. The following person(s) have my permission to receive my personal health information: _____

Authorization and Release: I authorize payment of insurance benefits directly to this office. I authorize the doctor to release all information necessary to communicate with my insurance company, attorney, adjuster, healthcare providers, or payors to secure the payment of benefits. I understand that I am responsible for all costs of care regardless of insurance coverage or settlement. I give an assignment of health care lien against any claims or a third party to this office up to the owed balance for treatment. I also understand that if I suspend or terminate my recommended care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I have read and understood the information above in Terms of Acceptance, HIPAA Notice, and Authorization and Release.

Print Patient Name _____ Date _____

Signature _____

Please List Your 5 Major Health Concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any laboratory testing done in the past 1-2 years? Y N
Where and what testing? _____
_____

Have you ever worked in law enforcement? Y N
Have you ever worked in the military/military contractor? Y N
Have you ever worked 2nd or 3rd shift?
How often do you take time off from work or go on vacation? _____
Have you had any auto accidents or injuries? _____
Have you been hospitalized for any reason? _____
Have you had any organs removed?_____
Have you had any joint repair/replacements or hernia repair? Y N _____
Have you been diagnosed with any health conditions? _____
_____

Please circle activities affected by your current condition:

Bathing/Showering	Bending	Brushing teeth	Carrying or Lifting or Reaching
Movement/Exercise	Changing positions	Climbing stairs	Computer usage
Cooking	Dressing/socks	Caring of family/pets	Eating
Driving	Running/Sports	Getting out of bed	Chores/Yard Work
Laying down	Reading	Sexual activities	Sleeping
Sneezing/Coughing	Sitting	Standing	Work

Primary Care Physician

Name _____ Phone # _____
Address _____ Last Visit _____
City _____ State ____ Zip _____

Please list all medications/supplements you are currently taking and what they are for.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you have any of the following conditions in your health history or family health history?

Self	Family		Self	Family	
		Heart Disease/Stroke			Bypass surgery, blood clots, or stints
		High or Low Cholesterol			Kidney or Liver issues
		High or Low Blood Pressure			Low Blood Pressure
		Diabetes			Hypoglycemia
		Cancer			Auto-immune conditions
		Rheumatoid Arthritis			IBS/Crohn's/Ulcers/GERD/heartburn
		Osteopenia/Osteoporosis			Anemia
		Vitamin D Deficiency			Bladder Infections
		Depression or Anxiety			Alcoholism/Drug Addiction or Treatment
		Asthma			Autism or Sensory/Learning disorder
		Bedwetting			Growing Pains or Muscle Cramps
		Scoliosis			Seizures or Epilepsy
		Genetic Disorder/Mutation			Vaccine adverse reaction
		Hormone Imbalance			Menstrual Issues/Fertility Problems
		Numbness/Weakness			Difficulty Urinating
		Cold or color change in hand/feet			Joint Pain/Swelling

<u>Lifestyle</u>

How many hours of sleep per night? ____ Do you feel refreshed upon waking? _____
What position do you sleep in? Back Belly Side Other_____
Do you currently use sedatives, tranquilizers or sleeping pills? Y N _____
How old is your mattress? _____ Do you feel like your mattress is supportive for you? Y N
Do you use a pillow? Y N How old is your pillow? _____ Do you feel your pillow is supportive? Y N
How many glasses of water do you drink daily? ____
How many alcoholic beverages do you consume per week? _____
How many caffeinated beverages (including coffee, soda, tea, energy drinks) do you consume daily? _____
How many times do you eat out per week? _____
Are you currently recording your food intake or calorie intake? Y N
Are you currently using any weight loss products, programs, or a special diet? _____
How many servings or grams of protein do you consume daily? ___
How many servings of fruits and vegetables do you consume daily? ___
Do you have any food allergies? _____-_____
Have you ever had any allergy testing? Y N What kind? Skin scratch testing blood testing
Do you currently use anti-acids or laxatives? Y N _____
Do you smoke or use tobacco products? Y N If yes, how many times or cigarettes per day? ____
Number of hours commuting per week? ____
Number of hours spent at desk or computer per week? ____
Number of hours spent on screen time (TV/smart devices/tablet) per week? _____
Number of hours spent reading per week? _____
What is your current stress level? 0 1 2 3 4 5 6 7 8 9 10
On a scale of 1 to 10, what is your commitment level to making changes? 0 1 2 3 4 5 6 7 8 9 10
How many times per week do you perform cardiovascular exercise? ____
How many times per week do you perform resistance training or weight lifting? ____
Do you experience pain that prevents you from exercise or pain after exercise? _____
Are you at your ideal weight? Y N If no, what is your desired weight? _____
Have you tried any weight loss products, appetite suppressants, weight loss programs, diets previously? Y N
If yes, did you get results? Y N Did you keep your results? Y N

Males Only:

Have you ever had a prostate exam? Y N
Have you ever had your PSA tested? Y N
Do you have any issues with urinating? Y N
Do you have any issues with your prostate? Y N
Do you have any issues with erectile dysfunction? Y N
Have you ever taken testosterone before? Y N
Have you been diagnosed or think you might have low testosterone levels? Y N _____
Do you have any issues with libido? Y N

Females Only:

Do you currently have menstrual cycles? Y N When was your last cycle? _____
Any chance you could be pregnant today? Y N
Have you had a hysterectomy? Total Hysterectomy Partial Hysterectomy No
Do you have any issues with hormone imbalance or libido? Y N
Do you experience hot flashes? Y N

Trying/Pregnant Only:

Are you currently pregnant or trying to get pregnant? _____ How Many Weeks _____
When is your due date? _____ What type of provider are you using? Midwife Ob/Gyn Other
Where do you plan on delivering? _____ Do you have a birth plan? Yes No
Is this your first pregnancy? Y N If No, how many previous pregnancies? Vaginal ___ Csection ___
Miscarriages? Yes No D&C Natural Miscarriage
Have you had any complications or long term issues? _____

DOCTOR USE ONLY

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